Program Description / Disclosure Statement for CWC's Acquired Brain Injury Services 2015

Four 24/7 Residential homes: The Charlotte White Center's Level III Residential Housing Programs for Individuals with Acquired Brain Injury, (ABI) provides services to six individuals in a home in the Bangor area, three individuals in a home in Ripley, five individuals in one home in Dexter and to two individuals in our second home in Dexter.

Care Coordination for Individuals with Acquired Brain Injury: This service is for individuals who do not receive any other services from the Charlotte White Center. The Care Coordinator is responsible for ensuring that the needs of the individual are met by other agencies, professionals, technology, natural supports, etc.

CWC's Acquired Brain Injury homes provide focused rehabilitative, personal care and behavioral health services in support of an individual's ability to live in a residential setting. Residential employees are present nightly and at all other times when the residents are home. The support professionals provide services that enable the residents to maximize and maintain their independence and self-direction.

These homes are physically integrated into the Bangor, Dexter and Ripley communities and every effort is made for these residences to approximate other homes in the neighborhood. Our Bangor home, Church Road, is a six bed home for males and females who are 18 years of age or older. (The current age of residents ranges between late-forties to mid-fifties). The Ripley home, Chandler Hill Road, is a three bed home for males and females who are 18 years of age or older. (The current age of three male residents ranges between 42 and 52). One Dexter home, Garland Road, is a five bed home for males and females who are 18 years of age or older. (The current age of three male residents ranges between mid-thirties to mid-fifties. The female resident is 55 years old). The second Dexter home, School Street, has two 24/7 beds downstairs for males and females who are 18 years of age or older. The two residents are female, ages 51 and 57.

The Charlotte White Center accepts referrals for individuals from anywhere in the state who need Care Coordination Services.

Program eligibility requires the individuals to have a diagnosis of acquired brain injury and are determined to be medically and financially eligible as set forth by MaineCare regulations. These programs are for adults whose legal residence is the state of Maine. CWC accepts all functioning levels/intellectual capabilities of any individuals, as long as the program is able to meet each individual's needs by connecting with outside providers/resources. The programs ensure that all resident' medical, emotional, physical and cultural needs are met by consulting with outside agencies/personnel as needed.

Church Road, Garland Road, Chandler Hill Road and downstairs at School Street are residential homes that provide focused rehabilitative care in support of an individual's recovery in a residential setting, and to restore the resident to his or her best possible functioning level. These are all 24/7 Assisted living homes that provide rehabilitative care and for that reason, the homes are drug-free. This means that any use, transfer, distribution, manufacture or possession of alcohol, controlled substances, unauthorized drugs, intoxicants, drug paraphernalia, or any combination thereof is not allowed at the home, including vehicles parked at the home. All residents must abide by this policy in order to reside at any of these residences.

The Charlotte White Center's Brain Injury Program delivers services, in residential homes and individual's homes/apartments that focus on the unique medical, physical, cognitive, communication, psychosocial, behavioral, vocational, educational, accessibility, and

leisure/recreational needs of its residents with acquired brain injury. The program provides services that address:

- Minimizing the impact of impairments and secondary complications;
- Reducing activity limitations;
- Maximizing participation, including wellness, quality of life and inclusion in the community;
- Decreasing environmental barriers and
- Promoting self-advocacy

We recognize the individuality, preferences, strengths, and needs of the individuals we serve and their families/support systems.

CWC's acquired brain injury programs utilize current research and evidence to provide effective rehabilitation and supports future improvements by advocating for brain injury research.

We try our best to partner with the individuals we serve, families/support systems, and outside providers to foster an integrated system of services that optimizes recovery, adjustment, inclusion and participation. CWC engages and partners with providers to increase access to services by advocating for persons who have sustained a brain injury to regulators, legislators, educational institutions, research funding organizations, payers and the community at large.

The following services are provided at CWC's ABI Assisted Housing Program:

- Rehabilitation treatment in order to maximize each resident's ability to be as independent as he/she can be.

- Assistance with or supervision of activities of daily living including bathing, dressing, eating, toileting, ambulation, personal hygiene, grooming, and the performance of incidental household tasks essential to the activities of daily living and to the maintenance of the resident's health and safety.

- Supervision of or assistance with administration of physician ordered medication.

- Personal supervision and monitoring of each resident to ensure his/her health and safety, reminding the resident to carry out activities of daily living, and assisting each resident in adjusting to the facility and the community.

- Assisting in arranging transportation and making phone calls for appointments as recommended by medical providers or as indicated in the resident's plan of care.

- Observing and monitoring resident's behavior and reporting changes in the resident's normal appearance, behavior, or state of health to medical providers or supervisory personnel, as appropriate.

- Evaluating and facilitating the achievement of predicted outcomes for the residents served in the areas of behavior, cognition, communication, medical, pain management, physical issues as well as psychological and vocational issues.

- Reinforce the goals and services provided by the individual's day program, therapy services, (OT, PT, Counselor, Neuropsychiatric, etc.).

Services Provided by Community Home Supports:

The services offered are individually tailored supports to assist with the acquisition, retention or improvement in skills related to living in the community. These supports include the following:

- Adaptive skill development
- Assistance with activities of daily living, community inclusion, transportation, adult educational supports
- Social leisure development
- Services that assist the client to reside in the most integrated setting appropriate to his/her needs

Services are provided by CWC's Care Coordinators**:**

These services are a conflict-free service that assist clients in gaining access to needed waiver and State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is sought. Care Coordination Services also include responsibility for assisting the individual to access and coordinate natural supports, and monitoring and assurance of the implementation of the Care Plan. This includes monitoring of the health, welfare and safety of the individual. This service requires face-to-face contact between the Care Coordinator and the individual, at a minimum of every thirty days.

Employees Qualifications:

Employees are trained in Direct Support Professional Training, Acquired Brain Injury, CPR, First Aid, Mandt, Standard Precautions, Fraud and Abuse, Neglect, Exploitation, Documentation, Confidentiality, Emergency Protocols, reporting Incident/Accidents and Defensive Driving.

Direct Care Employees provide skills training, rehabilitation or personal care, as documented as a need on the resident's care plan. The various areas will either be provided by direct care employees or direct care employees will train the resident. There is treatment oversight by CWC's Medical Director or our Neuropsychologist.

Administrator's Responsibilities:

The administrator of the homes has the necessary authority to coordinate the provision of care and knowledge of the rehabilitation program. The administrator is responsible for the following, which is not limited to: overseeing the entire home, care providers, residents served, financial matters, provide staff and residents with education and appropriate trainings, refer the residents to appropriate services, and be an integral part of each resident's team.

The administrator coordinates the provision of care to ensure the residents served achieve predicted outcomes by demonstrating the competencies which support the clinical coordination of care. The administrator secures ongoing medical input and care from CWC's Medical Director, Occupational Therapists, Physical Therapists, Neuropsychologists, primary care physicians, day program staff, therapists, each resident's team and any other needed providers. The administrator facilitates the decision-making processes regarding intake, assessments, service planning and service provision, as well as discharge and transition planning. The administrator with assistance from the Medical Director or Neuropsychologist, also facilitates the gathering of information to assist in the follow-up activities, to ensure that the discharge and transition

planning arrangements are completed and are communicated to the appropriate stakeholders and facilitates the implementation of the transition or discharge recommendations.

Waiting List:

CWC is not allowed to keep a waiting list for any ABI home or take any formal referrals for these homes. All requests or referrals are directed to the Program Manager of Brain Injury Services at OACPDS/DHHS. CWC is proactive in assisting individuals within our network by providing information to our providers, recipients, stakeholders, etc. and we are involved with the Brain Injury Network.

The referrals for Care Coordination are referred to CWC by the Department of Health and Human Services. This program is allowed to have a waiting list until the Care Coordinator is able to meet with the individuals or until the individuals get onto the ABI Waiver.

Transfer or Discharge:

In keeping with the mission of Charlotte White Center, our programs are designed to assist, support, and enable our residents/individuals with acquired brain injury to attain a higher level of neurobehavioral function. Given the person-centered nature of our treatment plans and care plans, which involve input from stakeholders and any relevant medical personnel/providers, there are three possible Discharge/Transition Plans. The first involves transitioning our residents to a less intrusive environment outside their home. This may take the form of placement in an apartment with daily living skill assistance or community rehabilitation services, an apartment with home health service assistance, or a return to their former place of residence prior to the acquired brain injury. The second involves transitioning the resident to a higher level of independence within his/her current facility. This is based on the resident's person-centered or individual treatment plan and is routinely assessed via the Mayo Portland Assessment, Comprehensive Assessment, Medical Eligibility Assessment or an Occupational Therapy Evaluation. The last type of transition plan involves transitioning the resident to a more restrictive environment should the resident exhibit a significant decline in function that may or may not be related to their acquired brain injury or exhibit medical or other complications that exceed our staff's competence and capabilities. Consideration would then be given to placement in a more restrictive environment, such as a nursing home, hospital, or inpatient rehabilitation facility.

Whenever a resident is transferred or discharged from a CWC residential program in non-emergency situations, the resident and/or his/her guardian will be given at least 15 (fifteen) days advance written notice to ensure adequate time to safely transfer to an appropriate placement. With any discharges, a CWC employee will indicate the reason(s)/plan for discharge on a discharge form and it will be placed in the resident's record. Referrals will be made as necessary and all appropriate people will be notified, such as: Guardian, case worker, licensing agency, etc. Appropriate information, including copies of pertinent records will be transferred with the resident to the new placement. There will also be an aftercare plan to ensure that the new placement is appropriate for the individual.

Discharge Criteria for CWC's ABI Community Services or Care Coordination:

1. Voluntary withdrawal from services
2. The client has moved from the area
3. No longer needed services
4. Moved into an nursing home

5. The individual is no longer deemed eligible for the service per the medical assessment tool or the Mayo Portland Adaptability Tool
6. Passed away

Grounds for Termination from CWC's ABI Homes:

1. Behavior, which poses a continuous threat of danger to self or others.

2. In order for the resident to remain at the facility, CWC has documented evidence that it would have to modify the essential nature of the program.

3. Resident extends absences from the facility beyond what has been established as clinically contraindicative to his/her goals.

4. The resident has not paid for his/her residential services in accordance with the contract between CWC and the resident.

5. CWC has provided documented evidence that a resident has violated the terms and obligations of the admission contract despite reasonable attempts to resolve any issues.

6. The resident's presence has resulted in substantial physical damage to the facility or the property of others residing or working there.

7. CWC has had its license revoked, not renewed or voluntarily surrendered.

HIGHLIGHTS

1. **CARF Survey –** Two consecutive **3** Year CARF Accreditations!!!!!

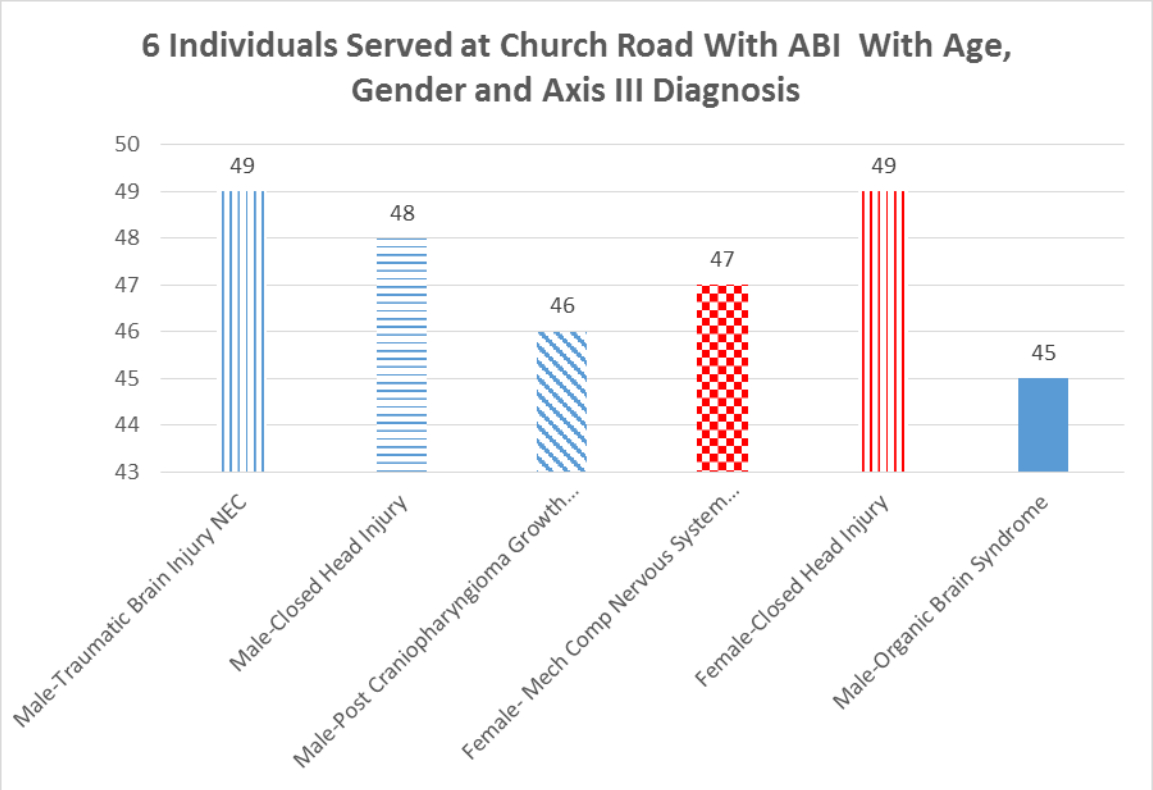
2. **Development in 2015**
   a. Garland Road went from a 4 bed home to a five bed home.
   b. Chandler Hill Road three bed home was opened
   c. School Street two bed 24/7 and two apartments were created
   d. Care Coordination for ABI services began

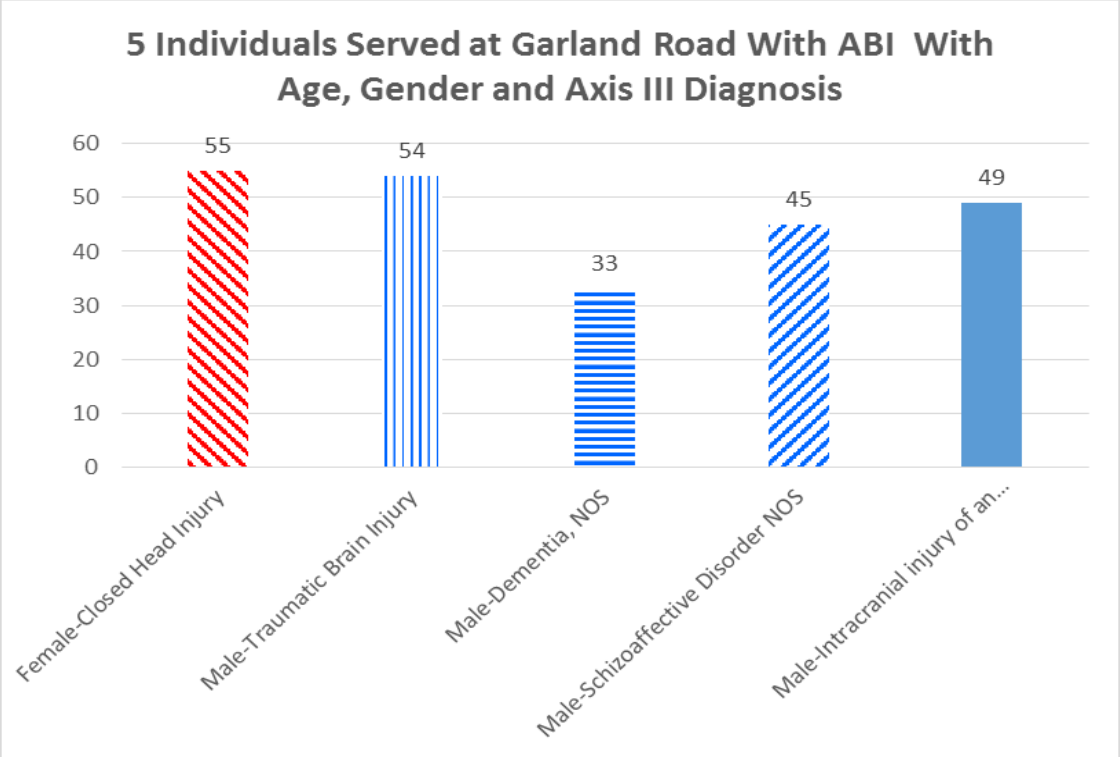
3. **Licensure**
   a. In 2011 and 2013, the Church Road Residential home received a two year license, with no deficiencies. In 2015 the Garland Road Residential home also received a two year license with no deficiences.

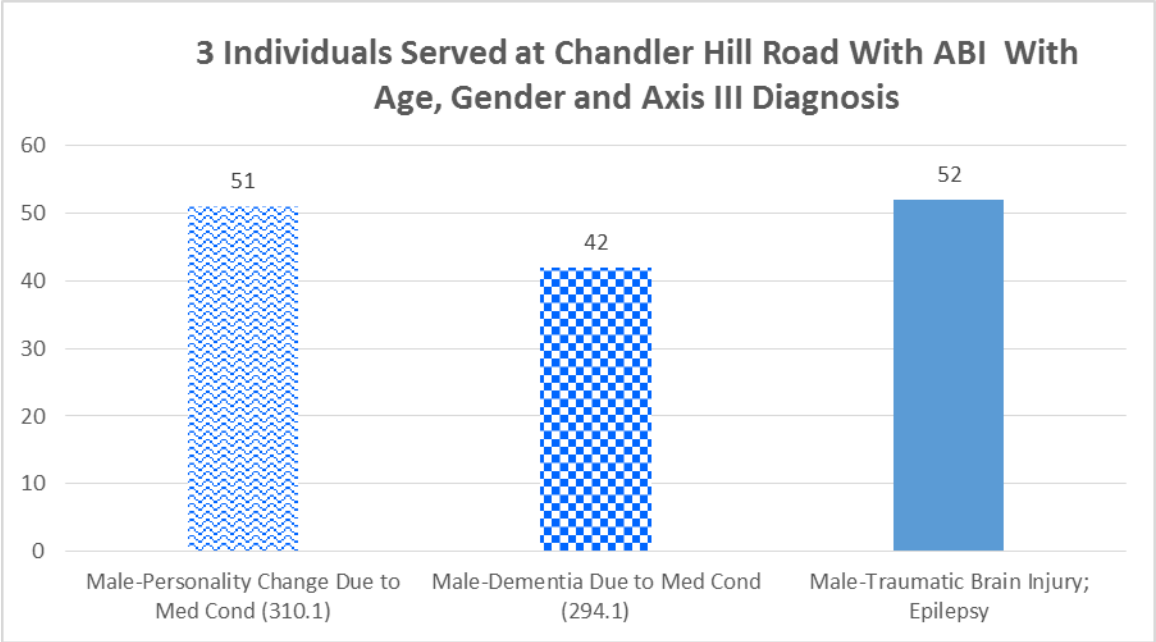
4. **Satisfaction Surveys**
   a. In 2014 there was a 94% very satisfied/satisfied outcome on the satisfaction of residential services at CWC's Acquired Brain Injury homes which were completed by the residents. We received a 100% very satisfied/satisfied outcome on the satisfaction surveys completed by outside providers.

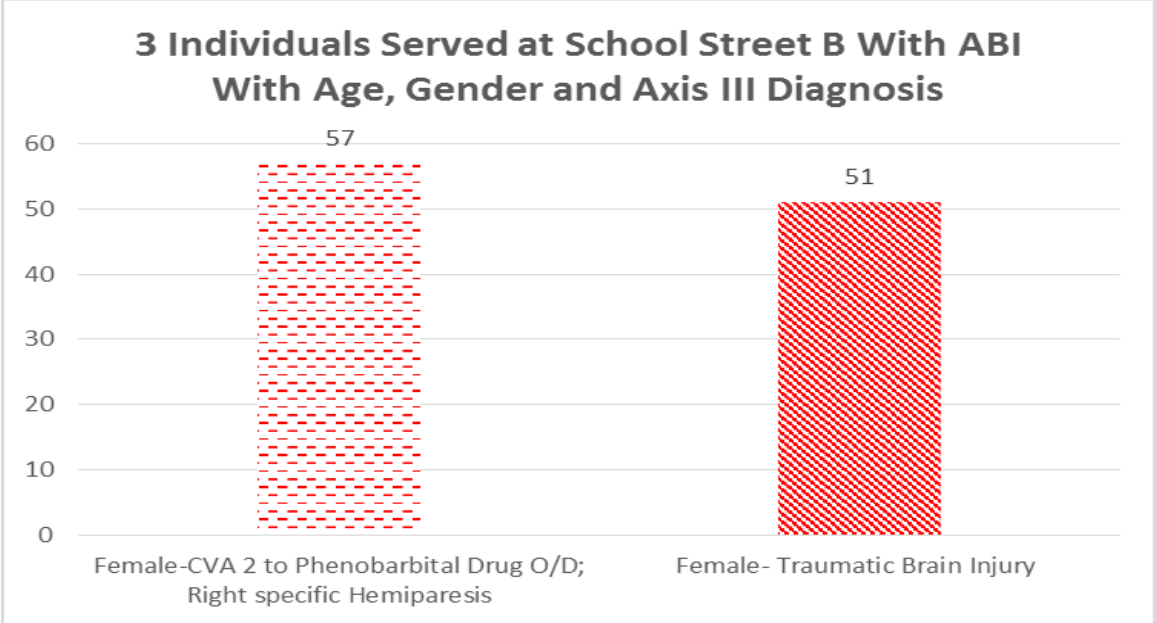
5. **Goals Achieved by Residents**
   a. During 2014, between the 6 residents at Church Road all residents achieved at least one of their goals and reached 46% of their goals for the year. Four residents reside at Garland Road in 2014 and they also reached 59.4% of their goals for the year!

6. **Planned Discharges**
    a. In 2015 one individual moved out of Church Road. Another Church Road resident moved to Garland Road, and one individual moved from Garland Road to a less restrictive environment.






3 Individuals Served at Chandler Hill Road With ABI With Age, Gender and Axis III Diagnosis
60
50
40
30
20
10
0
51
42
52
Male-Personality Change Due to Med Cond (310.1)
Male-Dementia Due to Med Cond (294.1)
Male-Traumatic Brain Injury; Epilepsy


3 Individuals Served at School Street B With ABI With Age, Gender and Axis III Diagnosis
60
50
40
30
20
10
0
57
51
Female-CVA 2 to Phenobarbital Drug O/D; Right specific Hemiparesis
Female- Traumatic Brain Injury